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ABSTRACT

This paper describes the Home-Based Crisis Intervention (HBCI) program in New York and the outcomes of a study that investigated the effectiveness of the program. The HBCI program provides short-term intensive in-home services to families with children who are at-risk for out-of-home placements. Counselors work with families to prevent psychiatric hospitalization or out-of-home placement. The intervention focuses on family strengths and needs by using a multifaceted approach that includes skills building, counseling, and the provision of concrete services. The program effectiveness study included 221 children (ages 5-17) who were experiencing a psychiatric crisis requiring immediate intensive intervention, hospitalization, or placement in another restrictive setting. Results indicate that despite additional resources and expansion of services in the HBCI program, hospitalization rates did not change significantly at the two participating hospitals. Rather than preventing hospitalization, in-home services may represent another community-based option for children whose safety and clinical needs are not as acute as children judged to require hospitalization. Children enrolled in in-home services gained in self-esteem and these gains were maintaining over the follow-up period. Also, most were able to avoid hospitalization during the initial period of service. (Contains 10 references.) (CR)

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Introduction Method Results Discussion References

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Introduction

Each year many children and their families present at emergency service settings seeking help for psychiatric crises. Little is known about the treatment that these children receive or the effectiveness of the treatment provided. If a child is assessed as not in need of immediate inpatient care, one option is the provision of intensive in-home services. These interventions, often modeled on the Homebuilders program developed for a child welfare population (Fraser, Pecora, & Haapala, 1991), have not been systematically evaluated to assess their outcomes when used for a mental health population. The purpose of this study was to assess the combined child, family, and system outcomes of three in-home psychiatric emergency programs all located in the same urban community.

In 1987, the New York State Office of Mental Health established Home-Based Crisis Intervention (HBCI) as an intensive in-home service option for families with a child in psychiatric crisis. HBCI is modeled on the Homebuilders program developed in Tacoma, Washington (Kenny, Madsen, Flemming, & Haapala, 1977). This program provides short-term intensive services to families with children who are at risk of out-of-home placement. Counselors work with two families at any time with a goal of preventing psychiatric hospitalization or out-of-home placement. The intervention focuses on family strengths and needs using a multifaceted approach including skills building, counseling, and the provision of concrete services.

A research demonstration grant (Evans, 1992) from the National Institute of Mental Health (1R18MH50357) and the Center for Mental Health Services (5HD5SM50357) allowed us to develop an enhanced HBCI program (HBCI+), based in part on lessons learned in prior research (Evans, et al., 1994). The study site is located in the Bronx, New York, a densely populated borough of New York City

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characterized by cultural diversity and intense poverty. In order to answer questions about the effectiveness of these two models, we further modified a generic case management program to create Crisis Case Management (CCM), an intensive, short-term intervention whose purpose was to do rapid assessment of child and family needs and to link to needed services. The development of CCM was to answer the question about whether a linkage and advocacy model of in-home services results in the same outcomes as in-home programs focused on skill building and treatment.

Details on all three interventions, which are provided in-home for 4 to 6 weeks, are available elsewhere (Evans, Boothroyd, & Armstrong, 1996). In this presentation, we will concentrate on aggregate data across the three program types.

Method

Children were referred to the study following evaluation by a child and adolescent team at two psychiatric emergency rooms. Children referred for consideration were assessed as being at risk of either hospitalization or out-of-home placement without immediate intensive intervention. If a child met the study criteria and the family and child were willing to participate, the family was randomly assigned to one of the three interventions. Criteria for inclusion were that the child be (a) between the ages of 5 and 17; (b) living in the Bronx with a natural, foster or adoptive family; and (c) experiencing a psychiatric crisis requiring immediate intensive intervention, hospitalization, or placement in another restrictive setting. Moreover, the child's family had to be willing to receive services, and the environment in which the child lived had to be safe. Data on multiple aspects of child and family status and functioning were collected on admission to the study, at discharge from the intervention (4&endash;6 weeks), and six months following discharge. Data reported in this manuscript are preliminary and are based on the first 221 children admitted to the study. Other presentations (Evans, Boothroyd, & Kuppinger, 1997; Boothroyd, Kuppinger, & Evans, 1997) focus on additional aspects of this study.

Results

To understand the characteristics of children referred to the study in the context of all children presenting at the emergency rooms, clinicians were asked to assess the overall dangerousness of each child's condition. The assessment device that was utilized was the Child and Adolescent Mental Health Assessment of Imminent Danger (Gutterman & Levine, 1992). On a five-point scale, ranging from none (0) to severe (4), children referred for hospitalization (N = 208) had a mean score of 2.64; those referred for in-home services (N = 179) had a mean score of 1.85; and those referred to other community-based services (N = 620) had a mean score of 1.14. All between-group

(N = 620) had a mean score of 1.14. All between-group differences are statistically significant at p = .05. There was also a perfect order effect between the seriousness of a child's condition, the child's assessed ability to participate in services, and the ability of the caretaker to provide a supportive environment and participate in services with the treatment environment selected by the clinicians (i.e., children identified as having the most severe clinical statuses, who were least able to participate in their own care and whose caregivers were least able to provide care, were more likely to be hospitalized). Children at the opposite extremes on these variables, however, were most likely to be referred for outpatient services. Children who scored as intermediate on the risk variables were those most often referred to the in-home intervention.

Additional characteristics of the 221 children served by the project in the three intensive, in-home interventions appear in Table 1. Particularly remarkable is the proportion of children with clinical diagnoses of psychotic disorders and the low incomes of their families, most of which are below the poverty line (see Evans, Boothroyd & Kuppinger, 1997).

One of the primary proximal outcomes of interest in this study is self-esteem. The Piers-Harris Children's Self-Concept Scale (Piers, 1984) was used to measure this variable. Based on the first 152 children who completed the three intensive interventions, the data show that the mean score at intake was 50.5, which was below that of a normative group of children with emotional disturbances. The data also show that the mean score at discharge had increased to 53.7, which is statistically significant at the .05 level. Figure 1 shows the subscale gains from entry to discharge. Children showed significant gains, ranging from .001 to .05, on all subscales except Popularity. A smaller sample (N = 98) of children with data from all three data collection points shows that the gains made between intake and discharge were retained at six months.

Child satisfaction with services is assessed at discharge from each of the in-home interventions. Children (N = 158) show high levels of satisfaction with nearly all aspects of their care. The only items with more than 20% of the children expressing dissatisfaction or a lack of clarity were: (a) knowing why the counselor or case manager came to see them initially; (b) being satisfied with the counselor or case manager getting them other services; and (c) being terminated from service before they were ready.

In regard to the disposition of children, using the most complete data available at this time, which includes the 221 children reported here and an additional 75 children recently admitted, 296 children and families have been referred to the study. Of these, 233 completed the intervention, while 38 were considered early terminations (i.e., they did not complete the entire intervention). Twenty-five of the children required hospitalization at some time during the intervention. The most usual placement for children at both admission and discharge (88.9%) was living with their

admission and discharge (88.9%) was living with their family or other relatives.

Discussion

The data presented reflect only a small sample of that collected during the research demonstration, which is still in progress. Based on these data, some questions have been raised regarding whether in-home crisis intervention programs are serving as a hospital diversion program in New York, as had once been expected. Clinicians, exercising their judgment, differentiate among children who are referred for hospitalization, for in-home services, or for other community-based services. Despite the increased capacity the grant resources have brought to serve children and families in their homes, hospitalization rates have not changed significantly at the two participating hospitals (about 20%). Rather than preventing hospitalization, in-home services may represent another community-based option for children whose safety and clinical needs are not as acute as children judged as requiring hospitalization. It has not been determined what the hospitalization rates would have been at these hospitals without the introduction of these additional resources. Also, initial discussions with other researchers working in this area of study indicate that the children seen in emergency settings in the Bronx have more serious problems than children assessed in settings elsewhere in the country (Gutterman, Evans, Levine, Boothroyd, & Drennan, 1996). Additional analyses are needed to answer the hospital diversion question.

Children enrolled in in-home services gained in self-esteem, and these gains were maintained over the follow-up period. Also, most were able to avoid hospitalization during the initial period of service. Avoidance of hospitalization assumes particular importance when considering the following points: (a) that many of these children appeared to be in crisis at the time of their presentation; (b) a significant minority were diagnosed with psychotic disorders and/or had been hospitalized previously; and (c) the overall dangerousness of the child's condition, on average, was determined to be moderate.

Since this study is still in progress, analyses have not yet been performed to examine the differential outcomes that may be associated with the three program models. There is support, however, for the assertion that children in psychiatric crisis and their families can receive effective, intensive supportive care safely in the community, and that gains in self-esteem persist for at least six months following discharge.

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